

Utah Provider Manual for Primary Care Plan

Division of Health Care Financing

Updated July 2006

DRUG CRITERIA and LIMITS

The pages which follow describe conditions of coverage and limits for the drugs listed. This list is updated by Medicaid Information Bulletins.

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ATYPICAL ANTIPSYCHOTIC ICD.9 CODES

- Age Group, 6 Years or less
- Atypical Antipsychotic ICD.9 Codes: Age Group, 7 - 19 Years
- Atypical Antipsychotic ICD.9 Codes: Age Group, ADULT

Explanation of Table Headings

LIMIT	Drug has a cumulative limit approved by the Drug Utilization Review (DUR) Board for any 30-day period. Drug does not qualify for early refills. Additional information on page 3.
COMMENTS	Indicates other pertinent information for the drug. Units are cc's for liquids = 1:1 tablets, capsules = 1:1 powders are usually grams to cc's to units 1:1
AGE	When this column is blank, Medicaid covers the item from birth through any age. If there are age limits either for a drug or for drug usage based on diagnosis, the age range is entered numerically. The patient's age on the date of service must be within the age range specified. For example, "0 - 20" means for ages from birth through age 20.
DIAGNOSIS	This is the diagnosis or diagnoses for which the drug may be approved. The criteria and age limits for authorization may vary with the diagnosis.
CRITERIA & INSTRUCTIONS	Specific information required by Medicaid before the item will be reimbursed. All criteria listed must be met, unless otherwise specified.
P A	P rior A uthorization is required by Medicaid when either of the following codes is entered in this column: T - Telephone Prior Authorization W - Written Prior Authorization. The pharmacist must obtain the prior authorization from Medicaid, unless noted otherwise, and write the authorization number on the prescription. When the P A column is blank, prior authorization is not required. References: <u>Utah Medicaid Provider Manual for Pharmacy Services</u> , SECTION 1, GENERAL INFORMATION, Chapter 6, Prior Authorization; SECTION 2, PHARMACY SERVICES, Chapter 2, Prior Approval; Chapter 4, Coverage Limitations; and Chapter 5, Special Drug Provisions.

How changes are marked on the Drug Criteria and Limits List

A vertical line in the margin indicates where text on a page has changed or been added.

An asterisk (*) marks where text has been removed.

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Drugs with Limits (No Prior Authorization)

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 4 - 9, Limits on Certain Drugs, some drugs are limited by quantity in any 30-day period. The drugs listed in the table below have a cumulative limit and do not qualify for early refills under Chapter 4 - 7, Early Refills. The limits are those approved by the Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs which exceed the limits may appeal to the DUR Board. All medications remain subject to all other requirements of the Utah Medicaid Pharmacy Program, as described in the Utah Medicaid Provider Manual for Pharmacy Services.

DRUG	LIMIT	COMMENTS	EFFECTIVE DATE												
Atypical Antipsychotics	By age for ICD-9 diagnosis code: 0 to 6 yrs 7 to 19 yrs > 19 yrs	See attachment for covered ICD-9 diagnosis codes. Correct code must be written on prescription by the prescriber for age and diagnosis.													
Celebrex		> 65 yrs - no PA required Under age 65 - requires a PA - 10 day supply limit	January 15, 2004												
Bextra		> 65 yrs - no PA required Under age 65 - requires a PA - 10 day supply limit	January 15, 2004												
Muscle Relaxants	Limit: 30 units in any 30-day period	Baclofen, tizanidine, and dantrolene are not included	October 1, 2005												
Sedatives - Hypnotics Dalmane, Sonata, Halcion, Ambien, Prosom, Doral, Restoril, Lunesta, Rezorem and their generic equivalents.	Limit: 30 units per 30 days	A cumulative limit is set to 30 units per 30 days for any combination of sedatives-hypnotics in therapeutic class specific H2E.	April 1, 2004												
Levothyroxine Products	Generic use mandated where AB equivalent exists; Proper substitution must be followed	<table><tr><td><u>Drug</u></td><td><u>Rating</u></td></tr><tr><td>Unithroid</td><td>AB1, AB3</td></tr><tr><td>Levoth.Sod. Mylan</td><td>AB1, AB2, AB3</td></tr><tr><td>Levoxyl</td><td>AB1, AB3</td></tr><tr><td>Synthroid</td><td>AB2</td></tr><tr><td>Levo-T</td><td>AB2, AB3</td></tr></table>	<u>Drug</u>	<u>Rating</u>	Unithroid	AB1, AB3	Levoth.Sod. Mylan	AB1, AB2, AB3	Levoxyl	AB1, AB3	Synthroid	AB2	Levo-T	AB2, AB3	July 31, 2004
<u>Drug</u>	<u>Rating</u>														
Unithroid	AB1, AB3														
Levoth.Sod. Mylan	AB1, AB2, AB3														
Levoxyl	AB1, AB3														
Synthroid	AB2														
Levo-T	AB2, AB3														

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DRUG	LIMIT	COMMENTS	EFFECTIVE DATE
Schedule II & III Short Acting Analgesics: -Propoxyphene/APAP -Hydrocodone/APAP -Codeine/APAP -Oxycodone/APAP -Oxycodone plain -Morphine plain -Codeine plain -Hydromorphone -Meperidine	Limit: 180 in any 30-day period	Narcotic analgesics in combination with ASA or ibuprofen are not included in this restriction. Liver toxicity occurs at APAP levels of 4 gms per day if taken on a routine basis.	January 1, 1999
Methadone	a. 150 tablets per any 30 day period. b. Open per ICD.9	a. For chronic non-malignant pain. b. For diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, end stage AIDS, or Pagent's Disease the correct ICD.9 must be written on the prescription by prescriber and entered into diagnosis field by pharmacist for full access.	
Schedule II Long Acting Analgesics ACTIQ	Absolute maximum cumulative limit of 120 units per 30 day period.	Covered only for diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature. Correct ICD.9 must be written on prescription by prescriber, and the pharmacist must enter that ICD.9 into the diagnosis field.	
Duragesic 25 mcg, 50 mcg, 75 mcg.	a. Cumulative limit of 15 patches for any combination of strengths per 30 days. b. Open per ICD.9	a. For chronic non-malignant pain. b. For diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, end stage AIDS, or Pagent's Disease the correct ICD.9 must be written on the prescription by prescriber and entered into diagnosis field by pharmacist for full access. 100 mcg patch not covered for chronic non-malignant pain.	
Morphine Long Acting Formulations	a. Cumulative limit of 90 capsules/tablets for any strengths per 30 days. b. Open per ICD.9	a. For chronic non-malignant pain. b. For diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, end stage AIDS, or Pagent's Disease the correct ICD.9 must be written on the prescription by prescriber and entered into diagnosis field by pharmacist for full access.	
Oxycodone LA Formulations (Oxycontin)	a. Cumulative limit of 90 capsules/tablets for any strengths per 30 days. b. Open per ICD.9	a. For chronic non-malignant pain. b. For diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, end stage AIDS, or Pagent's Disease the correct ICD.9 must be written on the prescription by prescriber and entered into diagnosis field by pharmacist for full access.	
Stadol	Limit: four vials in any 30-day period. (4 vials x 2.5 ml = 10 units)	The limit is due to frequent over-usage.	March 1, 1997

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DRUG	LIMIT	COMMENTS	EFFECTIVE DATE
<p>'Triptans' for Migraines</p> <p>Any combination of the following:</p> <ul style="list-style-type: none"> - Amerge® - Axert® - Frova® - Imitrex® - Maxalt® & MLT - Relpax® - Zomig® & ZMT 	Limit: 9 units per month per client		July 1, 2002
Ultram and Generics	Limit: 180 tablets in any 30-day period	Ultram is a non-scheduled drug for pain. Because of information concerning addicting properties for this drug, a monthly quantity limit was established.	March 1, 1997
Revatio	Limit: 5 units in any 30-day period	For Pulmonary Arterial Hypertension. Call help desk for quantity override.	January 1, 2006
Miralax	Limit: Cumulative limit of 1054 gms in 31 days.	Quantities in excess of 1054 gms will require a petition to the DUR Board.	July 1, 2002
Benzodiazepines	Limit: 120 units in any 30 day period	<p>No duplicate therapy allowed between long acting benzodiazepines; no duplicate therapy allowed between short/intermediate-acting benzodiazepines; duplicate therapy allowed with one long and one short/intermediate-acting agent.</p> <p>Short-acting agents: Alprazolam, clonazepam, lorazepam, oxazepam</p> <p>Long-acting agents: Chlordiazepoxide, clorazepate, diazepam, Xanax XR®</p> <p>Benzodiazepine agents in the sedative/hypnotics class (see above) are not affected by this policy.</p>	Implemented January 1, 2006 through April 1, 2006
Butalbital Containing Products	Limit: 30 units in any 30 day period		January 1, 2006
Diphenoxylate Containing Compounds	Limit: 30 units in any 30 day period		January 1, 2006
Spiriva	Limit: 30 dosage units per 30 days		January 1, 2006
Cymbalta	ICD-9 required	One of these two ICD-9 is required on any Cymbalta prescription. 311 - depressive disorders; 729.2 - neuralgias	January 1, 2006
Bupropion	ICD-9 required	One of these two ICD-9 is required on any Bupropion prescription. 311 - depressive disorders; 305.1 - smoking cessation	July 1, 2006

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Drugs Requiring Prior Authorization

DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Proton Pump Inhibitors (PPIs)		GERD symptoms and/or bleeding peptic ulcer disease	<p>1. Proton pump inhibitors (PPIs) are restricted to one dose daily. The point-of-sale's 30 day cumulative limit logic will be used to limit PPIs to thirty doses in any 30 day time period effective July 1, 2001. The 30 unit limit is for all PPIs in any combination and any oral strength (same logic as used with the narcotic/APAP limits).</p> <p>2. Twice daily dosing is allowed with a prior approval (PA) for presenting acute states of GERD, ulcers, or hypersecretory conditions for up to sixty days. Physicians (prescribers) are responsible for providing the pharmacy with written documentation supporting any of these conditions.</p> <p style="padding-left: 20px;">a. The Medicaid prior approval unit will issue a PA number to select pharmacy for a total time period of sixty days and 120 doses.</p> <p style="padding-left: 20px;">b. PA unit will contact Claims Management unit by e-mail and get an override for the PA. The e-mail is to be saved which creates the requisite audit trail.</p> <p>3. Any requests for PPIs with dosing outside of the above limits will require the patient's physician to petition the DUR Board.</p>	W	Criteria effective July 1, 2002

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Ritalin / Methylphenidate	0 - 5 yrs.				Not a benefit for children from birth through age 5.
Ritalin / Methylphenidate	6 - 18 yrs.	1 Attention Deficit Disorder 2 Narcolepsy			
Ritalin / Methylphenidate	19 and older	1 Narcolepsy 2 Major or Atypical Depression 3 Organic Brain Disorder includes but is not limited to: a. Congenital, such as cerebral palsy b. Infectious, such as encephalitis c. Traumatic, such as closed head injury d. Metabolic, such as diabetes 4 Mental Retardation: a. If the patient exhibits injurious behavior b. Is hyperactive c. Has both diagnoses. <i>Continued on next page</i>	Medical necessity must be established. Provider must document the nature of the mental disorder and why methylphenidate is medically necessary. Documentation includes current evaluation, medical history, physical exam and history of treatment including effective and ineffective therapies given.		

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Ritalin / Methylphenidate	19 and older	<i>cont. from previous page</i> 5 Attention Deficit Disorder	<p>Ritalin / Methylphenidate for the diagnosis of Attention Deficit Disorder (ADD and ADHD) for patients age 19 and older requires written prior authorization.</p> <p>Criteria for approval are listed below:</p> <ol style="list-style-type: none"> 1. If the patient has previously accessed Utah Medicaid for treatment of ADD with these medications, and the continuous use of treatment and drug is identified on the Utah Claims Payment History, prior authorization may be approved for one year without further testing. 2. Patients who come from out-of-state or whose medication has been paid by another source <u>and</u> who (1) have complete documentation required by Medicaid, including documentation of testing with an approved scale, and (2) have continuous use of medication may be approved for one year without further testing or psychiatric evaluation. 3. Patients who have no records of testing or previous use, or who have had a lapse in treatment for ADD from childhood and now present with symptoms of ADD as an adult, must have a diagnosis of ADD by one of the following methods: <ol style="list-style-type: none"> a. The Wender Utah Rating Scale with a score of 46 or greater. A copy of this scale may be obtained by contacting Medicaid Information; or b. The Conner test scale; or c. A level 2 psychiatric evaluation by a psychiatrist or a psychologist which results in a diagnosis of ADD; or d. Other validated testing which has been approved by the Department of Health and the Drug Utilization Review Board. 	W	<p>Attention Deficit Disorder: Any of the following contraindications preclude payment for Ritalin for adults with ADD:</p> <p>Antisocial Personality Disorder. Schizotypal personality disorder or traits. Borderline personality disorder or traits. Active substance abuse or dependence.</p> <p>Reauthorization will be based on data supplied by the provider to validate improvement of function of the patient.</p>

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Amphetamines	0 - 2 years				Not a benefit for ages 0 through 2 years.
Amphetamines	3 - 18 years	① Attention Deficit Disorder (ADD) ② Narcolepsy	Prescribers must hand write a correct ICD-9 code on all Medicaid pediatric prescriptions for amphetamines such as Adderall®, Dexedrine®, and Desoxyn®. The accepted ICD-9 codes are for the hyperkinetic syndrome of pediatrics. Telephoning the code to a pharmacy after the fact is not acceptable.		Criteria effective August 1, 1999
Amphetamines	19 and older	① Narcolepsy ② Traumatic brain injury ③ Treatment resistant depression ④ Attention Deficit Disorder (ADD and ADHD)	Amphetamines for patients age 19 and older require written prior authorization. 1. PA criteria for the diagnosis of Narcolepsy, Traumatic brain injury, or Treatment resistant depression are: a. History and physical report; b. Medical need must be documented; c. Documentation of failed treatments or medications used to treat diagnosis of treatment resistant depression. 2. PA criteria for the diagnosis of Attention Deficit Disorder (ADD and ADHD) are: A. If the patient has previously accessed Utah Medicaid for treatment of ADD with these medications, and the continuous use of treatment and drug is identified on the Utah Claims Payment History, prior authorization may be approved for one year without further testing. B. Patients who come from out-of-state or whose medication has been paid by another source <u>and</u> who (1) have complete documentation required by Medicaid, including documentation of testing with an approved scale, and (2) have continuous use of medication may be approved for one year without further testing or psychiatric evaluation. C. Patients who have no records of testing or previous use, or who have had a lapse in treatment for ADD from childhood and now present with symptoms of ADD as an adult, must be diagnosed with ADD by one of the following methods:	W	For all diagnoses, a maximum of one year's prior approval may be granted. Extension or renewal will require proof of improvement with data/documentation supplied by the provider and physicians. For ④ Attention Deficit Disorder, any of the following contraindications preclude payment for Ritalin for adults: <ul style="list-style-type: none"> – Antisocial Personality Disorder – Schizophrenia – Schizo-affective disorder – Schizotypal personality disorder or traits – Borderline personality disorder or traits – Active substance abuse or dependence

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
			<ul style="list-style-type: none"> - The Wender Utah Rating Scale with a score of 46 or greater. A copy of this scale may be obtained by contacting Medicaid Information; or - The Conner test scale; or - A level 2 psychiatric evaluation by a psychiatrist or a psychologist which results in a diagnosis of ADD; or - Other validated testing, which has been approved by the Department of Health and the Drug Utilization Review Board. 		
Lufyllin (dyphylline)			<p>Lufyllin (dyphylline) requires written prior authorization (PA) . Physician must obtain PA. Criteria are as follows:</p> <ol style="list-style-type: none"> 1. Failure with two or more other agents of the xanthine therapeutic class <ol style="list-style-type: none"> a. Documentation in writing b. Blood level of generic failures c. Description of failure 2. Failure with generic equivalent of Lufyllin elixir, Lufyllin-GG elixir, or Lufyllin-EPG elixir formulations <ol style="list-style-type: none"> a. Documentation in writing b. Blood level of generic failures c. Description of failure 	W	<p>Therapeutic class: A1B, Xanthines: GGN.SEQNO: 000130, 000133, 000132</p> <p>combinations: dyphylline/ephedrine/gg/penobar b: 000164, 000165 dyphylline/gg: 000170, 000168</p> <p>Criteria effective October 1, 1996</p>

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Darvon®, Darvocet N®		History must show pain management failure of at least one other type of analgesics.	<p>Darvon®, Darvocet N® require written prior authorization. The requirement applies to the brand names only. Generic forms of propoxyhene do not require prior authorization. The physician or prescriber must supply to the pharmacy the following.</p> <ol style="list-style-type: none"> 1. A copy of the physician's prescription for Darvon or Darvocet-N must be submitted with the request for prior authorization (PA). 2. The prescriber must hand-write on prescription "name brand medically necessary". NOTE: Patient preference is not considered a medical necessity. 3. Physician must supply copy of patient record/history showing reason for medical necessity. 4. History must show pain management failure of at least one other type of analgesics. 5. Documentation must show trial period on generic with documentation of failure and why the generic version failed. <p>PA can be given for six months, after which the PA must be renewed.</p>	W	The quantity limit is 180 tablets per prescription. The prescription limit is twelve prescriptions in six months.

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
5-HT ³ Receptor Antagonists: Zofran® (ondansetron HCL) Anzemet® (dolasetron mesylate) Kytril® (granisetron HCL)		❶ Nausea or vomiting related to oncology treatment (chemotherapy or radiotherapy) or pregnancy ❷ Prevention of postoperative nausea and/or vomiting ❸ Pregnancy related nausea or vomiting (morning sickness):	❶ Prevention of nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy; Prevention of nausea and vomiting associated with radiotherapy in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen ❷ Prevention of postoperative nausea and/or vomiting ❸ Pregnancy related nausea or vomiting (morning sickness): <u>The documentation from the patient's medical record must exhibit at least one of the following conditions:</u> a. Duration of onset of nausea/vomiting has exceeded one week, and patient has failed to respond to other medications including at least a trial on each of pyridoxine and phenothiazines and benzodiazepines. b. Patient has received I.V. rehydration with imminent hospital admission if vomiting can not otherwise be controlled. Approval may be given for up to ninety (90) days. Maximum units are 90 tablets (30 per month).	T	PA for one year maximum units: ❶ Oncology -360 tablets max ❷ Prevention of post/op n/v - 30 tablets max. ❸ morning sickness 90 days: 90 tablets max. at 1 qd

Criteria effective July 1, 2001.

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Regranex (becaplermin) 0.01% topical gel			<p>Regranex (becaplermin) 0.01% topical gel requires written prior approval. Physician must provide requested attachments. Regranex has been approved by the FDA for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply. Regranex is to be used as an adjunct to, and not a substitute for good ulcer care practices including initial sharp debridement, pressure relief and infection control.</p> <p>The efficacy of Regranex Gel for the treatment of diabetic neuropathic ulcer that do not extend through the dermis into subcutaneous tissue (State 1 or II, IAET [International Association of Enterostomal Therapy] staging classification) or ischemic diabetic ulcers has not been evaluated.</p> <p>Criteria for PA are:</p> <ol style="list-style-type: none"> 1. Rule out venous ulcers and/or arterial ulcers. 2. Patient must be diabetic, either Type I or Type II. Existing prescription for insulin or oral hypoglycemics: Y/N _____ Not covered for diabetic ulcer above ankle. 3. Patient must have stage III or IV diabetic foot or ankle ulcer as defined in the International Association of Enterostomal Therapy guide to chronic wound staging, 1989. These states included ulcers into the subcutaneous tissues. 4. The first prior approval is for 8 weeks only. A 30% reduction in ulcer size must be achieved before a second prior is obtained. 5. Size and shape of ulcer must be documented. Length: _____ width: _____ Draw shape: 6. Any given ulcer is limited to treatment of a maximum of 60 grams of Regranex. 7. The subcutaneous diabetic foot ulcer may not exceed 3 cm in diameter or total surface area of 9.42 cm². Size and shape of ulcer must be documented. Length: _____ width: _____ Draw shape: <p><i>Continued on next page →</i></p>	W	<p>Regranex supplied as single 15 gm tube</p> <p>Criteria effective October 1, 1999</p>

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Regranex (becaplermin) 0.01% topical gel, continued			<p><i>Continued from previous page</i></p> <p>8. Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered.</p> <p>9. The second prior approval is for 8 weeks only. Size and shape of ulcer must be documented. Length: _____ width: _____ Draw shape:</p> <p>10. Any given ulcer is limited to treatment of a maximum of 60 grams of Regranex.</p>		

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Panretin® Topical Gel 0.1% (9-cis- retinoic acid) (alitretinoin)		Kaposi's Sarcoma (KS)	<p>Panretin® Topical Gel 0.1% (9-cis-retinoic acid) (alitretinoin) requires written prior approval.</p> <p>9-cis-retinoic acid has been approved for Kaposi's Sarcoma (KS), a frequently encountered malignancy in HIV-positive patients. 9-cis-retinoic acid is an isomer of trans-retinoic acid (tretinoin) or Retin-A®.</p> <p>terms: KS Kaposi's Sarcoma PRA partial response area PRH partial response height</p> <ol style="list-style-type: none"> Panretin is not indicated when systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement.) Note. Board approved Retin-A use (via PA) for KS treatment pre-Panretin. Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma. <p>Primary number of KS lesions: _____ Estimated total square centimeters: _____</p> <ol style="list-style-type: none"> 60 day trial period on 0.1% Retin-A gel - by prior approval. If client sustains an improvement of >25% or more from base line (both PRA and PRH){see table 1}, remain on Retin-A gel. <p>Primary number of KS lesions: _____ Estimated total square centimeters: _____</p> <ol style="list-style-type: none"> If improvement < 25%, then 0.1% Panretin Gel* Panretin may be tried for a thirty (30) day trial period. Patient must sustain partial response defined as a 25% or more improvement from baseline for PRA and 25% or more improvement from baseline of PRH before additional coverage is approved. <p>Single 60 gm tube of Panretin gel is approved. Number of KS lesions : _____ Estimated total square centimeters: _____</p> <ol style="list-style-type: none"> A sixty (60) day treatment period with Panretin Gel** may be approved. Patient must sustain 50% or more improvement from baseline. Four 60 gm tubes cumulative maximum per year. <p><i>Continued on next page →</i></p>	W	<p>How supplied: Panretin 0.1% gel Description: single 60gm tube</p> <p>Generic name: 9-cis-retinoic acid</p> <p>(1gm = 1 unit)</p> <p>*(4) 60gm tubes cumulative maximum per year. (240gm/units/per-year) *Each tube requires a new prescription from the physician.</p> <p>Criteria effective October 1, 1999.</p>

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DRUG	AGE	DIAGNOSIS	CRITERIA & INSTRUCTIONS	P A	COMMENTS
Panretin® Topical Gel 0.1% (9-cis- retinoic acid) (alitretinoin)			<p><i>Continued from previous page</i></p> <p>7. Continued use of Panretin—State of continued improvement</p>		

Table 1. ACTG Response Criteria as Applied for Topical Therapy+

Assessment of lesions is limited to only the cutaneous lesions treated. Each lesion assessed for height and diameter. The response evaluation of each KS index lesion will be classified according to the following system:	
Complete Response (CR)	Decrease in lesion area to zero and biopsy documenting absence of KS cells
Clinical complete Response (CCR)	Decrease in lesion area to zero
Partial Response area (PRA)	Decrease in lesion area by 50% or more from baseline without concurrent increase in height of lesion from flat (macular) at baseline to raised (plaque-like or nodular)
Partial Response Height (PRH)	complete flattening of a lesion raised at baseline (decrease in height from nodular or plaque-like to macular) without concurrent increase in lesion area by 25% or more from baseline
Stable Disease (SD)	Lesion does not meet evaluation criteria for CR, CCR, PR, or PD
Progressive Disease (PD)	Increase in lesion area by 25% or more from baseline area, or an increase in height from flat (macular) at baseline to raised (Plaque-like or nodular)

+table 1 supplied by Ligand Pharmaceuticals

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INHALERS		LIMIT IN ANY 30 DAY PERIOD			
Effective April 1, 2002, the cumulative number of inhalers in any 30-day period is limited for a Medicaid client. The limit is set by class (excepting Foradil and Serevent which are limited by NDC number). This means the highest number in any one class is the maximum. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength. There are two groups of inhalers: oral and nasal. For each group, the limits are stated below.					
Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
Nasal Anti-inflammatory Inhalers	beclomethasone	Beconase	6.7	80	2
	beclomethasone	Beconase	16.8	200	2
	beclomethasone	beconase AQ	25	200	2
	fluticasone	Flonase	16	120	1
	trimcinolone	Nasacort	10	100	3
	triamcinolone	Nasacort AQ	16.5	120	2
	flunisolide	Nasalide	25	200	3
	flunisolide	Nasarel	25	200	3
	mometasone	Nasonex	17	120	1
	budesonide	Rhinocort	7	200	2
	budesonide	Rhinocort AQUA	8.4	120	2
	beclomethasone	Vancenase	16.8	200	2
	beclomethasone	Vancenase AQ	25	120	1
	ORAL INHALERS	Generic Name	Brand Name	Product Size	Doses per Inhaler
Beta 2 agonists and Sympathomimetics	Albuterol	generic	17 gm	200	4
		Proventil	17 gm	200	4
		Proventil HFA	6.7 gm	200	4
		Ventolin	6.8 gm	80	4
			17 gm	200	4
		Ventolin Rotacaps		100	4
	Bitolterol	Tornalate	16.4 gm	300	3
	Formoterol	Foradil		18	3
				60	3
	Metaproterenol	Alupent	14 gm	200	3
	Pirbuterol	Maxair	25.6 gm	300	3
		Maxair autohaler	2.8 gm	80	2
			14 gm	400	2
	Salmeterol	Serevent	6.5 gm	60	2
			13 gm	120	2
		Serevent Diskus		60	2
	Terbutaline	Brethaire	10.5 gm	300	3

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Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
Anticholinergics	Ipratropium	Atrovent	14 gm	200	3
	Ipratropium / Albuterol	Combivent	14.7 gm	200	3
Corticosteroids	Beclomethasone	Beclovent	6.7 gm	80	4
			16.8 gm	200	4
		Qvar	7.3 gm	100	4
				100	4
	Budesonide	Pulmicort Turbuhaler		200	3
	Flunisolide	AeroBid, AeroBid-M	7 gm	100	3
	Fluticasone MDI	Flovent 44 mcg, 110 mcg, and 220 mcg	7.9 gm	60	4
				60	4
				60	4
			13 gm	120	4
				120	4
	Fluticasone DPI	Flovent Rotadisk 50 mcg, 100 mcg, and 250 mcg		120	4
				60	3
				60	3
				60	3
	Triamcinolone MDI	Azmacort	20 gm	240	3
	Fluticasone / Salmeterol DPI	Advair diskus 100/50		60	2
		Advair diskus 250/50		60	2
		Advair diskus 500/50		60	2
Mast cell stabilizers	Cromolyn MDI	Intal	8.1 gm	112	3
			14.2 gm	200	3
	Nedocromil MDI	Tilade	16.2 gm	112	3

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Orlistat (Xenical) 120mg capsules		hypercholesterolaemia	<p>Orlistat (Xenical) requires written prior authorization (PA). Criteria are:</p> <ol style="list-style-type: none"> Covered only as an adjunct to a treatment regimen of diet, exercise, behavior modification, and one or more antihyperlipidemic medications (specifically LDL lowering agent(s) – niacin, bile acid sequestrants, and/or HMG Co A reductase inhibitors). Patient must have experienced treatment failure (defined as not being at NCEP goal for LDL cholesterol based on patient risk factors * \$) after three months of therapy at maximally tolerated doses of antihyperlipidemic agents (niacin, bile acid sequestrants, and/or HMG Co A reductase inhibitors). <p>* LDL goals by NCEP criteria: No CHD + < 2 risk factors → goal is LDL < 160 No CHD + ≥ 2 risk factors → goal is LDL < 130 CHD, ASVD or diabetes mellitus → goal is LDL < 100 * Cardiac Risk Factors as defined by NCEP guidelines:</p> <ul style="list-style-type: none"> - Male ≥ 45, female ≥ 55 - Family history of premature CHD (first degree relative, male < 55, women < 65 with MI or sudden cardiac death) - Current cigarette smoking - Hypertension - HDL < 35 - Diabetes - HDL ≥ 60 is a negative risk factor <ol style="list-style-type: none"> Orlistat must be used in addition to maximally tolerated doses of niacin or bile acid sequestrants, and/or HMG Co A reductase inhibitors; diet, exercise and behavior modification. First time period for authorization is 90 days, during which patient must achieve a reduction in LDL cholesterol of 5% from baseline (immediately prior to starting Orlistat) Additional prior authorizations will be in six month increments. Initial LDL levels must be documented, both pre initiation/during therapy of niacin, bile acid sequestrants, and/or HMG Co A reductase inhibitors; and pre orlistat therapy. 	W	<p>Recommended dose: No more than one capsule three times a day.</p> <p>Criteria effective July 1, 2000.</p>

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DRUG	AGE	DIAGNOSIS	CRITERIA	PA	COMMENTS
			<p>7. Orlistat will not be covered for use for weight loss or for the reduction of isolated elevated triglyceride levels.</p> <p><u>Check List for Orlistat Prior Authorization:</u></p> <ol style="list-style-type: none"> 1. Patient name: _____ 2. Prescriber: _____ 3. Patient weight: _____ (Patient weight must be recorded for each PA time span.) 4. Height: _____ 5. Cardiac risk factors (circle if patient has) <ul style="list-style-type: none"> - Male \geq 45, female \geq 55 - Family history of premature CHD (first degree relative, male $<$ 55, women $<$ 65 with MI or sudden cardiac death) - Current cigarette smoking - Hypertension - HDL $<$ 35 - Diabetes - HDL \geq 60 is a negative risk factor 6. Goal LDL for patient (by NCEP guidelines) _____ 7. LDL prior to all drug therapy: _____ 8. LDL after maximally tolerated niacin, bile acid sequestrants, and/or HMG Co A reductase inhibitors: _____ (This should be the same as the pre-Orlistat LDL.) 9. Current antihyperlipidemic regimen: _____ 10. LDL after 90 days of orlistat: _____ (For reapproval, this must be at least 5% lower than value in number 6.) 		

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DRUG	AGE	DIAGNOSIS	CRITERIA	PA	COMMENTS
Oseltamivir phosphate (Tamiflu7) 75mg Capsule	> 17 yrs.	1. influenza A influenza B 2. prophylaxis	<p>1. <u>Diagnosis of influenza A or influenza B</u> Oseltamivir phosphate (Tamiflu7) requires prior authorization (PA), which may be requested by telephone. Covered only for patient at high risk from diagnosed and documented disease states or immunodeficient patient. The term immunodeficient includes: HIV/AIDS or other diseases that affect the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids; oncology agents; immuno-suppressive agents.</p> <p>Documentation must be provided that demonstrates that one other household member or residential member currently has documented influenza A or Influenza B. (Verbal from doctors office)(Lab work in a Nursing Home)</p> <p>2. <u>Prophylaxis</u> Covered only for patients at high risk from diagnosed and documented disease states of: a. severe cardiopulmonary conditions b. immunocompromised patients c. fragility due to extreme age (greater than 65 years).</p>	T	<p><u>Diagnosis of influenza A or influenza B</u> Limit: Tamiflu is dosed at 75mg capsules twice daily for 5 days. Therefore, the limit is ten capsules or tablets per year.</p> <p>The FDA has not cleared Tamiflu for children ages 17 and younger.</p> <p><u>Prophylaxis</u> 7 day treatment for prophylaxis. Limit of 14 tablets.</p> <p>Criteria updated July 1, 2001</p>
Zanamivir (Relenza) 5mg amp	> 13 yrs.	influenza A influenza B	Zanamivir (Relenza) requires prior authorization (PA), which may be requested by telephone. Covered only for patient at high risk from diagnosed and documented disease states or immunodeficient patient. The term immunodeficient@ includes: HIV/AIDS or other diseases that affect the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids; oncology agents; immuno- suppressive agents.	T	<p>Dose: 10mg bid delivered via oral inhaler for five days</p> <p>Limit: one box of 20 5mg amps per year.</p> <p>Criteria effective April 1, 2000.</p>

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DRUG	AGE	DIAGNOSIS	CRITERIA	PA	COMMENTS
Tracleer	>12	pulmonary arterial hypertension (PAH) in patients with WHO class III or IV symptoms (WHO = World Health Organization)	<p>Physician obtains written prior approval. Six months' approval when following criteria are met:</p> <ol style="list-style-type: none"> 1. Covered only for patients with documented class III or class IV pulmonary arterial hypertension. 2. Copy of prescription from physician. (copy to Medicaid) 3. Name, address, phone number of prescribing physician. (to Medicaid) 4. Name, address and phone number of pharmacy. 	W	<p>Females can not be capable of becoming pregnant</p> <p>Contraindicated for patients with moderate to severe liver impairment.</p> <p>Contraindicated for patients taking cyclosporine or glyburide.</p> <p>Dose: 62.5mg b.i.d. for 4 weeks, then increased to 125mg b.i.d. (Maximum)</p> <p>Medicaid Cost: approximately \$32,000/yr</p> <p>Criteria effective April 8, 2002</p>
Modafinil (Provigil)		narcolepsy multiple sclerosis	<p>Prior authorization must be obtained by physician. Labeled Indication: Improve wakefulness in patients with excessive daytime sleepiness associated with narcolepsy. Dose limited to 400 mg qd. Psychosis has been reported at >600 mg/day. Age: > 16</p> <p>Covered off Label Indication: Treatment to offset sedation related to multiple sclerosis treatment modalities; dose limited to 200 mg qd.</p> <p>Six month maximum prior approval will be granted. Any of the following disorders precludes payment of modafinil.</p> <ol style="list-style-type: none"> a. Antisocial Personality Disorder b. Schizo Typical Personality Disorder or Traits c. Borderline Personality Disorder or Traits d. Active substance abuse or dependence 	T	<p>DEA: Schedule IV</p> <p>Cost for 30 days treatment at: 200 mg = \$145.53 400 mg = \$291.06 NOTE: There are potential interactions with drugs that inhibit, induce, or are metabolized by cytochrome P-450 isoenzymes including drugs such as carbamazepine, phenobarbital, phenytoin, tricyclics.</p> <p>Criteria effective July 1, 2002</p>

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NSAIDS					Duplication limited to first duplication
COX-2 Inhibitors	>65		Covered without PA		Duplication not allowed between COX-2 Inhibitors
COX-2 Inhibitors	0-64	analgesic	Covered for 10 days for pain management	T	telephone prior is required Duplication between NSAIDS not allowed
COX-2 Inhibitors		anti-inflammatory	Covered as an anti-inflammatory for clients having documented or diagnosed: GERD; Barrett's Syndrome; peptic ulcer; gastro hypersecretory conditions; or documented gastric bleeding caused by other NSAIDS	W	Covered if client on concomitant anticoagulant therapy Covered if client on concomitant oral corticosteroid therapy Duplication not allowed between COX-2 Inhibitors Dosing limited to labeled amounts
Non Sedating Antihistamines excepting loratadine formulations			Criteria for prior approval for these legend drugs includes: FAXed copy from patient charts documenting failure on loratadine due to specified adverse drug reaction or failure of efficacy while patient is on loratadine.	W	Over-the-counter loratadine formulations covered without a prior approval for up to 30 doses/30 days Zyrtec syrup for age 0-10 does not require a prior approval. non-sedating antihistamines limited to 30 doses/30 days.

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Bladder anti-spasmodics long acting formulations			criteria for prior approval consists of documented failure on short acting oxybutynin within the last 12 months.	W	
Olux foam (clobetasol propionate)			criteria for prior approval consists of documented failure on generic formulations of olux foam creams or ointments within the last 12 months.	W	
Luxiq foam (betta-methasone valerate)			criteria for prior approval consists of documented failure on generic formulations of luxiq foam creams or ointments within the last 12 months.	W	

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